

HEALTH CARE DIVISIONAL COUNCIL

**Workplace Violence Campaign Workshop – January 8, 2009
Region 1**

Personal Assistance and/or Special Needs request form

PLEASE PRINT

NAME _____

LOCAL _____

IF APPLICABLE, PLEASE FILL IN AND RETURN TO TINA FURMAN ALONG WITH YOUR ATTENDANCE/ADVANCE FORM, **NO LATER THAN Wednesday, DECEMBER 10, 2008.**

- Blind or visually impaired
- Deaf or hearing impaired
- Wheelchair hub to hub measures: _____cm
- I use crutches and need to be near an elevator
- I will need assistance evacuating my room
- Food allergies (please specify) _____
- Vegetarian

Please specify any other requirements: _____
